THERAPEUTIC ALLIANCE WITH ABUSER ALTERS IN DID: THE PARADOX OF ATTACHMENT TO THE ABUSER

Ruth A. Blizard, Ph.D.

Ruth A. Blizard, Ph.D., is in the private practice of psychology in Vestal, New York.

For reprints write Ruth A. Blizard, Ph.D., P.O. Box 129, Vestal, New York 13851-0129.

ABSTRACT

Abuser alters present a dilemma in the treatment of adults with dissociative identity disorder, because they often undermine the therapy as well as re-abuse the patient. They are paradoxical because they were created to help the child survive abuse, but continue to do so by abusing the self. They were often modeled after an abusive primary caretaker to whom the child was attached. Object-relations and attachment theories clarify how creation of the abuser personality serves to preserve the attachment to the abusing caretaker. By understanding how abuser alters function to maintain attachment, contain overwhelming memories, and protect against abuse, therapists can better engage abuser alters in a therapeutic alliance. Empathy, cognitive reframing, and gentle paradoxical techniques can help host and abuser personalities become more empathic toward one another, develop common purpose, and begin integrating. By working through the transference, attachment to the internalized abusive caretaker is replaced by a healthy attachment to the therapist in the therapeutic alliance.

One of the most difficult aspects of treating persons with dissociative identity disorder (DID) is working with abuser alters. These are personalities which abuse the patient externally, by causing physical or sexual harm to the patient's own body, or internally, by presenting verbal criticism, frightening visual images or somatic pain. In addition to abusing the patient, the abuser alter may also actively attempt to sabotage the therapy. These personalities may openly express anger at the therapist's attempts to stop the patient's self-abuse, but often also covertly undermine these efforts. Therapists often find that their endeavors to help the patient stop self-abuse are thwarted by the tenacity with which patients conceal, protect, or cling to abuser personalities. In some cases, the abuser personality may feel threatened by the host's increasing attachment to the therapist and consequent rejection of the abuser alter. The abuser personality may also perceive the therapist as trying to undermine its power over the host.

The abuser personality was a part of the self that was split off or dissociated in order to help the self to survive, both emotionally and physically. Paradoxically, this dissociated part of the self had to do so by turning against the self and causing emotional or physical injury. In many cases, the therapist can begin to engage abuser personalities in a therapeutic alliance by empathizing with the dilemmas they have faced. Instead of merely trying to contain or bargain with abuser personalities, the therapist can begin to work collaboratively with them to transform the manner in which they perform their functions from harsh and abusive to compassionate and nurturing.

It is essential for therapists to be aware that not all abuser personalities can be productively engaged in therapy, and in fact, some may be extremely dangerous. Ross (1989) comments, "Most persecutors can be brought into the therapy ... They have a number of positive qualities ... in which the host may be deficient" (p. 259). But he goes on to caution, "In forensic cases persecutors may be sadistic sex murderers ... and beyond rehabilitation" (pp. 259-260). Hall (1989) describes an attempt to treat a patient with DID who had a sociopathic alter who did not present in therapy. This alter very cunningly committed a gruesome murder of which the host personality apparently had no awareness. She commented:

> Entrenched antisocial components may resist integration not only for fear of surrendering their individuality, but more because they wish to retain their power to rule or destroy the person at all costs. ... The grandiose nature of such personalities is so pervasive that they may feel strangely immune to death or punishment, almost as a terrorist sees death as no deterrent ... The prognosis may be questionable for MPD patients with such characteristics, because they may have an inability to develop the trust essential for lasting therapeutic change. (1989, p. 87)

It is important to determine whether an abuser alter is capable of engaging in the therapy. Discovering whether there is an entrenched, sociopathic personality may be very difficult, because such alters may remain carefully hidden and never reveal themselves to the therapist. The process of evaluating for the presence of dangerous, antisocial alters is beyond the scope of this paper. However, if abuser alters can be engaged by the therapist by mirroring the importance of their roles, and they respond by beginning to develop some working relationship with the therapist, their capacity for therapeutic change can then be assessed.

In many patients with DID, there is an intense attachment between an abuser alter and the host or other alters. When patients are asked to describe how abuser alters first came to be, they often tell stories that suggest that these alters were created to help preserve attachments to abusive caretakers on whom the patient was dependent during childhood. Attachment and object relations theories can contribute to understanding how maintaining attachment to an abusing caretaker was necessary for the child's psychic survival. When a therapist can understand the role of abuser alters in maintaining attachment, and how that interacts with their roles in the containment of memories and emotions, control of pain, and protection from further abuse, the therapist can understand the paradoxical role of abuser alters and begin to reframe their functions as necessary and adaptive. This provides a framework from which the therapist can support abuser personalities' adaptive goals, while helping them to see that their harsh methods are not always consistent with those goals.

ABUSER ALTERS

Abuser personalities have been described as internal persecutor alters (Putnam, 1989; Ross, 1989) and malevolent ego states (Watkins & Watkins, 1988). Ross, Norton, and Wozney (1989) found that in a series of 236 cases of DID, 84% of patients were observed to have internal persecutor alters. Persecutor personalities can often be identified as introjects of an abuser (Putnam, 1989; Ross, 1989).

Abuser alters have been observed to abuse the host or other personalities physically, sexually, verbally, through somatic pain or visual images, or in severe cases, through hallucinated episodes. The form of the abuse may often be a reenactment of the manner in which the patient was abused as a child. Physical abuse often takes the form of hitting, cutting or burning the body. Sexual self-abuse may occur by inserting objects into bodily orifices, or may involve imagining or remembering scenes of abuse while engaging in self-stimulation. Verbal abuse may consist of internal voices shouting at, criticizing, or berating the patient. When abuser alters inflict somatic pain, they may be eliciting body memories of physical or sexual abuse. Abusive visual images may consist of visions of frightening objects such as snakes or bugs, or intrusive images of gruesome scenes of abuse. Hallucinated

abuse may consist of flashbacks of childhood abuse (sometimes elaborated in fantasy) complete with auditory, visual, and tactile components, which the patient perceives as externally perpetrated assaults or rapes.

Containment, Control, and Protective Roles
Abuser personalities have been understood as having four primary functions:

1) They maintain the dissociative defenses used to isolate and contain traumatic memories or to protect the host from revealing secrets that may have been life-threatening (Putnam, 1989). For example, Ivan's "Angry Part" produced frequent intrusive images of genital organs being cut with a razor to warn when he approached too close to memories of abuse.

2) They hold feelings such as anger and rage that the host cannot tolerate (Putnam, 1989, Ross, 1989), or dare not express for fear of retaliation by the abuser (Watkins & Watkins, 1988). When Tammy felt angry because her mother blamed her for her father's abuse, an abuser alter would cause Tammy to cut herself. In this way she could act out her rage without risking her mother's retaliation, and she could also cause herself to dissociate her emotional hurt and anger. As the child develops into an adult, the abuser alter may also serve to control rage against others by directing it toward the self.

3) They may inflict pain on the host personality as a means of taking control of the pain inflicted by the abusing caretaker (Watkins & Watkins, 1988), or as a means of identifying with the aggressor and disavowing their own vulnerability to pain and degradation (Howell, 1996). When Milton felt overwhelmed by rejection and depression, an abuser alter would cause him to cut himself. This enabled him to focus on the physical pain while dissociating from the emotional pain. He also reported feeling more powerful because he was able to be in control of the pain and endure it.

4) They may attempt to protect the host by being suspicious of persons who might abuse them (Ross, 1989; Watkins & Watkins, 1988), or by punishing the host to control behavior that could expose them to further abuse (Goodman & Peters, 1995). When Wilma dared to acknowledge that she herself might want to come to therapy, a sadistic alter would cause her to hit herself repeatedly, causing severe bruises. For Wilma, to want anything for herself was to risk "asking for too much." Her abuser alter was punishing her to prevent her from risking anticipated rejection and humiliation.

247

Attachment Functions

Abuser alters may provide a means for the child to tolerate a caretaker who is alternately abusing and nurturant by allowing the child to encapsulate the caretaker's abusive characteristics. By dissociating good and bad aspects of the caretaker, the child can preserve the attachment to the "good" caregiver. Abuser alters may also serve to maintain the child's attachment to the caretaker when there was little or no nurturance and abuse was the primary way the caretaker engaged with the child. Maintaining a relationship with the caretaker may have been of equal or greater importance to emotional and physical survival than avoiding the abuse, as the case of Rebecca demonstrates. Rebecca's Satan personality reenacted her father's abuse of her by inserting objects into her vagina. He explained, "That's how I show her I want her. Everybody always pushed her away, so she felt like she wasn't a person, but when her father wanted her for sex, then she felt like she was somebody."

During some of these episodes when her Satan alter sexually abused her, Rebecca actually hallucinated an entire sexual assault. She would hear someone breaking into the house and climbing the stairs, see her attacker, and have tactile sensations of being raped. Satan elaborated on his reasons for producing this hallucinated abuse, "That's what I have to do to keep her close to me. I don't want her going out. Men only want her for one thing and then they hurt her. She doesn't need anyone else but me." In addition to intimidating her so that she would not seek contact with men and risk further abuse, Satan was also possessively trying to strengthen her attachment to him.

As this example illustrates, when an abuser personality is an introject of an abusive primary caretaker of the child, there is often an intense attachment between the host and abuser personality. If maintaining the relationship with the caretaker is as important to survival as avoiding the abuse, this presents a terrible dilemma for the child. Attachment and object relations theories can shed some light on the nature of this dilemma, the defenses used to cope with it, the paradoxical role of the abuser personality, and some therapeutic principles which can be used to help the adult patient resolve the dilemma.

ATTACHMENT THEORY AND OBJECT RELATIONS

In the first half of this century, Fairbairn (1952) broke with the earlier psychoanalysts by positing that in humans, the primary motivator was not biological drives, such as hunger, sex or aggression, as Freud had theorized, but rather a relationship or attachment to another human being. This principle provided the foundation for attachment theory and much of object relations theory.

Attachment Theory

Bowlby (1969, 1973a & b, 1988) theorized that in early childhood the dominant pattern of attachment to the primary caretaker becomes a template which the child then imposes on all relationships. This template shapes the child's perceptions of and reactions to the object as if to follow the primary attachment pattern. He described three distinct patterns of attachment: secure, anxious-resistant, and anxious-avoidant. An excellent review of attachment theory and its application to clinical practice is provided by Biringen (1994).

A new pattern – disorganized/disoriented attachment – has since been described by Main & Solomon (1990). In this pattern, the child has no consistent pattern of attachment. The child may evidence disorientation by simultaneously displaying contradictory behaviors, such as looking away while approaching the parent, or fluctuating between intense approach and avoidance toward the caregiver. This pattern is frequently observed in children who have been abused (Cicchetti & Carlson, 1989; Liotti, 1992). Adults with a disorganized/disoriented pattern of attachment tend to have a history of childhood abuse and often exhibit dissociation (Alexander & Anderson, 1994).

In persons with DID, it is often observed that differing patterns of attachment have been incorporated into the various personalities. In particular, abuser alters can be viewed as displaying disorganized/disoriented attachment behaviors, characteristic of the contradictory pattern of attachment to the abusing caretaker.

Object Relations Theory

Object relations theorists describe how the child forms internalized representations of the self and the object (e.g., Kernberg, 1984, 1985, 1986; Masterson, 1976, 1981). In object relations theory, object refers to the object of attachment, which is the primary caretaker in the case of a child. These are stable, internalized representations of the self, the object, and the affect linking the two. They are derived from the child's experience of the early relationship with his or her primary caregiver. For example, the internalized object-relations representation might involve a self that is confident and competent, an object that is predictable and protective, and an affect that is calm and happy. In another case, the self may be represented as weak and uncertain, the object as unpredictably available and supportive, and the affect linking the two as anxious. Or the self may be represented as capable but unlovable, the object as rejecting, and the affect as empty. These constellations correspond to Bowlby's secure, anxious-avoidant, and anxious-resistant attachment patterns, respectively.

Object Relations and Attachment to the Abusing Caretaker

The schizoid dilemma, described by Fairbairn's student Guntrip (1989), appears to correspond closely with the disoriented/disorganized pattern of attachment. The schizoid dilemma exists because the self is represented as powerless and bad, and the object as dangerous. The affect is abandonment depression (Masterson, 1976) when the object is

absent, and terror when the object is present. This constellation is frequently seen in persons who have been abused by their primary caretaker. Although Fairbairn did describe the environment of the infant who experiences the schizoid dilemma as dangerous, there was little explicit discussion of the direct role of childhood trauma in the development of psychopathology in the object relations literature until recent years (Gunderson & Sabo, 1993, Blizard & Bluhm, 1994; Davies & Frawley, 1994; Gunderson & Chu, 1993). Two of Fairbairn's hitherto unpublished articles discuss attachment to the bad object (D. Scharff & Birtles, 1994).

Even when the object is rejecting or abusive, the child clings to avoid feeling the abandonment depression (Masterson, 1976). Several animal and human studies show that attachment to a caregiver is necessary for healthy social development, and, in fact, the infant clings more strongly when the caregiver is abusive (Van der Kolk, 1987). This clinging has been described as "traumatic bonding" by Dutton and Painter (1981). Infants exposed to unpredictable eruptions from caretakers and prolonged experiences of helplessness were able to obliterate pain from consciousness and participate in "sadomasochistic" play with the caretaker (Fraiberg, 1982; Galenson 1986). Based on more recent work on trauma and dissociation, we could understand this now as the child dissociating pain in order to engage in attachment behavior with the caretaker (Braun & Sachs, 1985; Frischholz, 1985; Putnam, 1985, 1991; Wilbur, 1985). Traumatic bonding in children can result in an enduring pattern of attachment to abusive partners in adults (Young & Gerson 1991).

If the child is driven to maintain a strong attachment to the primary caregiver, and experiences an intense abandonment depression when the attachment is lost, then the child faces a special set of problems when the primary caregiver is also an abuser. The child may have to go to great lengths to create defenses that will allow the preservation of the attachment to the abusive object (Blizard & Bluhm, 1994). Only some of these defenses can be explained as a means of avoiding the trauma. An understanding of the attachment to the abusing caretaker offers an explanation of the tenacity with which the abuse survivor clings to the introject of the abuser or to the reenactment of abuse by the caretaker.

ATTACHMENT, OBJECT RELATIONS, AND FORMATION OF ABUSER ALTERS

Because the dilemma of maintaining an attachment to a caretaker who is severely abusive may seem impossible to resolve, some abused children may resort to the defense of dissociation (Braun & Sachs, 1985; Frischholz, 1985; Putnam, 1985, 1991; Wilbur, 1985). Freyd (1996) presents a cognitive theory of traumatic amnesia based on betrayal by a caretaker on whom the child depends. Barach (1991) discusses dissociation as a form of detachment from the abusive caretaker. While detachment from the abuse may be necessary for the child's survival, dissociation can also be used to preserve the attachment to the caretaker.

The child cannot resolve the dilemma of a caretaker who is both necessary for, and threatening to, survival. The child may dissociate the internalized representations of the caretaker into "good" and "bad" or nurturing and abusive images (Blizard & Bluhm, 1994; Marmer, 1991). It is the thesis of this article that when abuse is severe and chronic, the child may create dissociated self representations which have their own patterns of attachment to the abusive and nurturing object representations. This enables the child to separate abusive from non-abusive attachment relationships with the caretaker. This helps to prevent the self structure from being overwhelmed by the no-win characteristics of the abuse. To preserve this separation, these self representations may become highly dissociated from one another. With time, some may become elaborated into separate identity states or alter personalities.

The child may also attempt to gain psychic control of the abusive relationship by identifying with the aggressor. A self representation that identifies with an introject of the abusive caretaker may develop into an abuser personality. By forming an abuser personality that identifies with the aggressor, the child gains a sense of control and power, and maintains the attachment by identifying with the abuser. By dissociating or disembodying the vulnerable self representation (Howell, 1996; Young, 1992), the child may find the pain more tolerable because he or she feels in control of it. The paradoxical nature of dissociation simultaneously allows the child to maintain the attachment to the abuser introject and to feel powerful by disembodying the vulnerable self representation. And, unlike abusing caretakers, abuser alters cannot abandon the child, because they are maintained internally.

Ironically, while maintaining attachment may be one of the primary function of abuser alters, their attachment needs may be so overwhelming that they avoid any external relationships for fear of becoming dependent and vulnerable to abuse. If their sense of self-sufficiency is threatened, they may attack the host to reaffirm their control and disavow any feeling of vulnerability.

Host Personalities

In contrast to abuser personalities who remember how they were abused and have a strong narcissistic investment in their role, host personalities are often empty and depleted, remember little or nothing of the abuse, and cling to the abusive caretaker, about whom they may maintain a vague, distorted, or idealized image. In order to maintain their fragile self image and ability to function in the outside world, host personalities often need to avoid awareness of both the abuse and the alters that were developed to deal

with it. It is difficult for host personalities to participate in therapy in a helpful way, because they have so little access to either the history of abuse or the defenses developed to survive it. Some host personalities may be quite willing to turn over therapy to other personalities, while other hosts may stalemate treatment by refusing to let alters talk. In contrast, abuser alters often have more insight into their development, their relationship with the abusing caretaker, and the dynamics of the relationships among the personalities in the system.

Case Study

The case of Rebecca illustrates how she developed two abuser alters from split object representations of her parents. It demonstrates the ways in which these representations allowed her to maintain her attachments to the "good" and "bad" aspects of her parents, as well as to preserve her sense of self as both good and powerful. The attachments with both parents were reenacted internally, with abuser alters, as well as externally, in adult relationships.

Both of Rebecca's parents were severely physically and sexually abusive. While her mother was extremely rejecting, her father was very possessive of her. His primary mode of interaction with her was violent sexual abuse, but he alternated this with idealization.

The host personality, Rebecca, could speak of her mother as rejecting and humiliating and her father as attentive, but she remembered no physical or sexual abuse. Her internal representations of her parents were vague and one-dimensional. Although she was able to function effectively in her job as a teacher, she was unable even to engage in casual social conversation with her colleagues.

Rebecca split her representation of her father into two alters – Marvin and Satan. She had separate self representations – Little Becky and Becca – to relate to each of these. Little Becky remained a child, and happily remembered her father, Marvin, taking her fishing or to work with him. In this way, she could preserve a good self and object, and an idealized attachment. Her alter, Satan, was an introject of her father's violent aspect, through whom she could identify with her father as the aggressor. In describing his own creation, Satan explained that his purpose was to protect Becca by caring about her more than anyone, so that she would not need anyone else, and thus could not be hurt by them. By abusing her sexually, Satan both incorporated the power of Rebecca's father and maintained the attachment by reenacting the dominant form of relatedness between them.

Rebecca's mother never held or comforted her. But when her mother wanted to be comforted, she required Rebecca to stimulate her sexually. During these sexual contacts, Rebecca's mother eventually would express her rage through physical abuse . By dissociating the part of the relationship that soothed her mother, and dissociating the part

of her self representation that provided what her mother wanted, Rebecca created an alter, Butch, who was able to split off the sexual, comforting aspect of this relationship from the physically abusive aspects. In doing this, she could preserve a sense of her self as good and maintain a soothing attachment. Butch then reenacted this form of contact by picking up lesbian women in bars and providing sexual stimulation for them without allowing them to touch her.

The Harpy was an abuser alter Rebecca created by dissociating the physically abusive aspects of her representation of her mother. Much as with Satan, this allowed Rebecca to preserve her self by identifying with her mother's power and gaining mastery over pain. Because Butch could not maintain any kind of relationship with the women she picked up, she would feel alone and abandoned. Then she would switch to the Harpy alter, dissociate from her body, which she would perceive as belonging to a child self, Becky, and physically abuse herself. In this way, as the Harpy, she could disown her weak, submissive self and regain a feeling of control and power.

This case illustrates how the creation of abuser alters enabled this patient to preserve some attachment to each of the abusing parents by dissociating the abusive elements of the relationships from the benign or at least more tolerable aspects. It also enabled her to incorporate a sense of power and control and dissociate her feelings of vulnerability. Understanding these principles provides invaluable tools for engaging abuser personalities in therapy.

ENGAGING ABUSER ALTERS IN THE THERAPEUTIC ALLIANCE

The paradoxical role of abuser personalities must be understood to engage them successfully in a therapeutic alliance. Abuser alters were originally created to protect the patient's physical and psychological survival. They continue to do so, in their own way, even if it means undermining the therapy, doing physical or emotional harm to the patient, or endangering her life. In order to bring abuser alters into the therapy in a positive way, the therapist must ally with the alters' protective and attachment roles, and help them to transform their behaviors from abusive to compassionate. The process of transformation can be accomplished by:

1. Reinforcing the abuser alter's strength and self-sufficiency;

2. Recognizing the attachment of the abuser alter to the host;

3. Reframing the abuser alter's actions as protective or nurturant;

4. Containing self-abusive acting out;

5. Use of paradoxical statements to create dissonance between protective goals and abusive means;

6. Pacing the therapy to maintain stability;

7. Working through the transference.

Reinforcing Abuser Alters' Strength and Self-Sufficiency

Engagement with abuser alters can begin by reflecting their narcissistic pride in their strength and self-sufficiency. Attempts to weaken abuser alters may provoke them to attack the host to demonstrate their control. Initially, it is best to avoid empathic statements that focus on the abuser alter's need for comfort, help or support. Feelings of attachment toward the therapist may seem frightening to abuser alters. These may stir up feelings of emotional deprivation and vulnerability to abuse or abandonment and may threaten the abuser alter's sense of self-sufficiency.

Recognizing the Attachment of the Abuser Alter to the Host

As the therapy progresses, abuser alters may begin to feel safer as their strength and self-sufficiency have been reinforced. Carefully acknowledging abuser alters' attachment to the host can increase their sense of safety and availability to the therapeutic process. It may be helpful to point out that an abuser alter cares more about the host than the abusive caretaker, and would never want to harm the host the way that caretaker did. Even if their aggressive treatment of the host appears to be a direct reenactment of the abuse, abuser alters often take great pride in being able to control the self-abuse so that it is less painful or injurious. Reframing their behavior in this way calls attention to their protective and nurturant attitudes, and appeals to their narcissistic pride. This can motivate them to become more careful, and eventually more caring. If the therapist can identify the abusive actions of abuser personalities as performing a protective or attachment function, and reframe these accordingly, then it may be possible to begin to draw abuser alters into a therapeutic alliance. In contrast, criticizing or interfering with the relationship of the host to the abuser alter may induce separation anxiety or abandonment depression, which both host and alter will strenuously resist.

Developing an empathic relationship with abuser personalities has two benefits. First, abuser alters feel safer in speaking with the therapist because recognition of their positive role in survival reduces the threat to their existence and attachment. Second, abuser personalities can begin to internalize the therapist's empathy and use it in relating to the host more sensitively.

Reframing the Abuser Alter's Actions as Protective

Reframing abuser alters' actions as protective or nurturant allows them to shift the focus from acting out to understanding the purpose of these actions. As abuser alters feel more affirmed in the protective aspects of their roles, they are able to tolerate more cognitive dissonance about the harsh methods they are using. The therapist can then support the alters' efforts to contain overwhelming memories, control rage, or ameliorate the fear of abandonment. While helping them to do these things in a less abusive, more compassionate manner, abuser alters become more engaged in the therapeutic process and begin to see the therapist as an ally.

Containing Self-Abusive Acting Out

Although empathy with the abuser alter's protective functions is essential, acting out of self-abuse must be contained if therapy is to progress. This is next to impossible if no relationship has been established with the abuser personality. Contracting with the abuser alter can be helpful when the client is in danger, but it is only a temporary measure. It is far more powerful to work with abuser personalities by understanding their purposes and helping them to perform their functions more effectively, without acting out the abuse. If abuser alters feel supported rather than threatened by the therapist, they will begin to have a stake in maintaining the therapeutic relationship. Gaining the therapist's approval or being offered time to talk in the therapy session can become powerful rewards for containing the acting out.

As some of the abuser alters' needs for attachment can be transferred onto the therapeutic relationship, their need to reenact the abusive attachment to the caretaker can be reduced. The therapist can help them to perform their defensive functions more effectively and adaptively, reinforce their pride in themselves, separate their self-image from that of the abusive caretaker, and contain and redirect their rageful acting out. This reduces their suspicion that the therapist is another potential abuser and facilitates a therapeutic alliance.

Use of Paradoxical Statements

The nature of abuser personalities lends itself well to the use of paradox as a therapeutic technique. The role of the abuser personality is a paradoxical one because the abuser alter and host are viewed as separate persons, and the abuser alter tries to protect the host by causing harm. The point of view of the host should not be presented to the abuser personality directly. That would threaten the abuser alter by breaking down the dissociation or appearing to criticize the attempts at protection. Carefully constructed, gentle paradoxical statements can validate the abuser alter's point of view, suggest a more effective, less abusive, means of accomplishing the same goal, and show how this will better protect the host or maintain attachment.

Paradoxical statements to abuser personalities should reframe the function of the abusive behavior, describe the relationship of the abuser alter to the host, and suggest how to resolve the paradox of trying to protect by harming:

251

1. Begin with a positive, narcissistically validating statement about the function of the abusive behavior, reframed as protective, nurturant or maintaining attachment. For example, "I know how powerful you are at controlling pain."

2. State the relationship of the abuser alter to the host, such as, "You want to stay in control of Milton so no one else can hurt him."

3. Gently suggest how to resolve the paradox. For example, "You've told me how much you hate the hospital being in control of him when you cut him. I wonder if next time you need to control the pain, you could paint a picture or write a story about cutting?"

An example of a paradoxical statement involving maintaining attachment and protection, rather than control of pain, might be, "I know that you care more about Rebecca than anyone else and don't want anyone to hurt her (function), so that is why you want to keep her close to you (relationship). So when she gets too close to someone who might hurt her, you wouldn't want to frighten her so much that she runs away from you. I wonder if, when you show her the picture of the snake, you could tell her that you are warning her away from danger so that she will know you are trying to protect her and stay close to you? (resolution of the paradox)."

Pacing the Therapy

The patient's resistance in therapy may be an effort to preserve the self structure by maintaining dissociation of overwhelming traumatic memories (Bromberg, 1995). Pacing the therapy is essential to preventing crises that may threaten the patient's functioning or survival (Fine, 1991). The system will only be able to tolerate minimal amounts of cognitive dissonance and gentle nudges toward breaking down dissociation. Paradoxical statements should be affirming and should contain concrete suggestions as to how to resolve the paradox. If statements are too frustrating or do too much to break down dissociation, the patient may become overwhelmed by memories of abuse and engage in self-abusive or suicidal behavior to increase the dissociation and reestablish the pathological equilibrium (Fine, 1990).

Working Through the Transference

Work with abuser alters can also be valuable in elucidating the nature of the transference to the therapist, which can be multifaceted and confusing in patients with DID (Loewenstein, 1993). If the abusing caretaker was at times engaging and positive toward the child and at other times violently abusive, the patient may respond positively to the therapist's interest in his or her activities, but may be hypervigilant for any change or inconsistency in the therapist that might signal a switch to abusiveness. On the other hand, if the abuser sought comfort from the child while sexually abusing him or her, then the therapist's attempts at comforting the patient may be seen as an entree to abuse.

As the transference is worked through, the abuser personality gradually recognizes that attachment to the therapist does not necessarily entail being abused, as did the relationship with the abusive caretaker. As the therapist supports the patient's efforts at self-sufficiency, the abuser alter learns to accept help without becoming over-dependent. This increasing sense of safety allows the abuser alter to become more engaged in a therapeutic alliance. As this alliance develops, and the patient begins to internalize the therapist, the attachment to the abusive object becomes less important, and the abuser personality becomes less abusive and more empathic. As the transference is worked through, the patient sees the therapist more as a real person and less as a projection of the abusive caretaker. As the patient gradually internalizes the real therapist as an object representation, there is less need to maintain the dissociative illusion of a relationship between host and abuser alter as separate persons. As the memories of abuse are worked through, and more adaptive, compassionate defenses are developed, dissociation decreases and host and abuser alters can increase their understanding of each other. Their perceptions, emotions and adaptive coping mechanisms can become more unified, all of which lessens dissociation and paves the way for eventual integration.

CONCLUSION

Abuser alters appear to be merely sadistic persecutor personalities, with no purpose other than to hurt the patient and sabotage the therapy. Paradoxically, in childhood they performed a number of protective and nurturant functions which enabled the patient to survive the dilemma of dependence on a severely abusive primary caretaker. In adulthood, abuser alters both protect the fragile self structure from being overwhelmed by traumatic memories, and provide an internalized object of attachment that can ameliorate extreme social isolation. If the therapist can understand the purpose of the abuser alter's behavior, reframe it empathically in terms of its positive defensive functions, and help the alter learn to perform these functions more effectively, adaptively and compassionately, the alter can begin to see the therapist as an ally. With its memory of the patient's history of childhood abuse, its insight into the defenses developed to survive the trauma, and its courage to take on difficult tasks, the abuser alter can join in the therapeutic alliance and become a genuine protector of the patient. ■

252

REFERENCES

Alexander, P.C., & Anderson, C.L. (1994). An attachment approach to psychotherapy with the incest survivor. *Psychotherapy, 31*(4), 665-675.

Barach, P.M.M. (1991). Multiple personality disorder as an attachment disorder. *DISSOCIATION, 4*(1), 117-123.

Biringen, Z. (1994). Attachment theory and research: Application to clinical practice. *American Journal of Orthopsychiatry, 64*(3), 404-420.

Blizard, R.A., & Bluhm, A.M. (1994) Attachment to the abuser: Integrating object-relations and trauma theories in treatment of abuse survivors. *Psychotherapy. 31*(3), 383-390.

Bowlby, J. (1969). *Attachment and loss, Vol. 1. Attachment.* New York: Basic Books.

Bowlby, J. (1973a). *Attachment and loss, Vol. 2. Separation.* New York: Basic Books.

Bowlby, J. (1973b). *Separation: Anxiety and anger.* New York: Basic Books.

Bowlby, J. (1988). Developmental psychiatry comes of age. *American Journal of Psychiatry, 145*(1), 1-10.

Braun, B.G., & Sachs, R.G. (1985). The development of multiple personality disorder: Predisposing, precipitating, and perpetuating factors. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 37-64). Washington, DC: American Psychiatric Press.

Bromberg, P.M. (1995). Resistance, object-usage, and human relatedness. *Contemporary Psychoanalysis, 31*(2), 173-191.

Cicchetti, D., & Carlson, V. (1989). *Handbook of child maltreatment: Clinical and theoretical perspectives.* New York: Cambridge University Press.

Davies, J., & Frawley, M.G. (1994). *Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective.* New York: Basic Books.

Dutton, D.G., & Painter, S. (1981). Traumatic bonding: The development of emotional attachments in battered women and other relationships of intermittent abuse. *Victimology: An International Journal, 6,* 139-155.

Fairbairn, W.R.D. (1952). *An object relations theory of the personality.* New York: Basic Books.

Fine, C.G. (1990) The cognitive sequelae of incest. In R.P. Kluft (Ed.), *Incest-related syndromes of adult psychopathology* (pp. 161-182). Washington, DC: American Psychiatric Press.

Fine, C.G. (1991). Treatment stabilization and crisis prevention: Pacing the therapy of the multiple personality disorder patient. *Psychiatric Clinics of North America, 14*(3), 661-676.

Fraiberg, S. (1982). Pathological defenses in infancy. *Psychoanalytic Quarterly, 51,* 612-635.

Freyd, J.J. (1996). Betrayal trauma: The logic of forgetting childhood abuse. Cambridge, MA: Harvard University Press.

Frischholz, E.J. (1985). The relationship among dissociation, hypnosis, and child abuse in the development of multiple personality disorder. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 99-126). Washington, DC: American Psychiatric Press.

Galenson, E. (1986, October). *The precursors of masochism: Protomasochism.* In M.M. Neril (chair), Masochism in Men and Women. Symposium conducted at Mills College, Oakland, CA.

Goodman, L., & Peters, J. (1995). Persecutory alters and ego states: Protectors, friends and allies. *DISSOCIATION, 8*(2), 91-99.

Gunderson, J.G., & Chu, J.A. (1993). Treatment implications of past trauma in borderline personality disorder. *Harvard Review of Psychiatry, 1,* 75-81.

Gunderson, J.G., & Sabo, A.N. (1993). The phenomenological and conceptual interface between borderline personality disorder and PTSD. *American Journal of Psychiatry, 150,* 19-27.

Guntrip, H. (1989). *Schizoid Phenomena, object-relations and the self.* Madison, CT: International Universities Press.

Hall, P. (1989). Multiple personality disorder and homicide: Professional and legal issues. *DISSOCIATION, 2,* 110-115.

Howell, E. (1996). Dissociation in masochism and psychopathic sadism. *Contemporary Psychoanalysis, 32*(3), 427-453.

Kernberg, O.F. (1984). *Object-relations theory and clinical psychoanalysis.* Northvale, NJ: Jason Aronson.

Kernberg, O.F. (1985). Internal world and external reality: Object relations theory applied. Northvale, NJ: Jason Aronson.

Kernberg, O.F. (1986). *Severe personality disorders: Psychotherapeutic strategies.* New Haven, CT: Yale University Press.

Liotti, G. (1992). Disorganized/disoriented attachment in the etiology of the dissociative disorders. *DISSOCIATION, 5*(4), 196-204.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M. Greenberg, D. Cicchetti, & N. Cummings (Eds.), *Attachment in the preschool years: Theory, research and intervention* (pp. 121-160). Chicago: University of Chicago Press.

Marmer, S.S. (1991). Multiple personality disorder: A psychoanalytic perspective. *Psychiatric Clinics of North America, 14*(3), 677-693.

Masterson, J.F. (1976). *Psychotherapy of the borderline adult: A developmental approach.* New York: Brunner/Mazel

Masterson, J.F. (1981). *The narcissistic and borderline disorders: An integrated developmental approach.* New York: Brunner/Mazel.

Putnam, F.W. (1985). Dissociation as a response to extreme trauma. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 65-98). Washington, DC: American Psychiatric Press.

253

Putnam, F.W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: Guilford.

Putnam, F.W. (1991). Dissociative disorders in children and adolescents: A developmental perspective. *Psychiatric Clinics of North America, 14*(3), 519-532.

Ross, C. A. (1989). Multiple personality disorder: Diagnosis, clinical features and treatment. New York: Wiley.

Ross, C.A., Norton, G.R., & Wozney, K. (1989). Multiple personality disorder: An analysis of 236 cases. *Canadian Journal of Psychiatry, 34*, 413-418.

Scharff, D. E., & Birtles, E. F. (1994). *From instinct to self: Collected works of W.R.D. Fairbairn, Vol. 1*. New York: Jason Aronson.

van der Kolk, B.A. (1987). The separation cry and the trauma response: Developmental issues in the psychobiology of attachment and separation. In B.A. van der Kolk, (Ed.), *Psychological trauma* (pp. 31-62). Washington DC: American Psychiatric Press.

Watkins, J.G., & Watkins, H.H. (1989) The management of malevolent ego states in multiple personality disorder. *DISSOCIATION, 1*(1), 67-72.

Wilbur, C.W. (1985) The effect of child abuse on the psyche. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality disorder*, (pp. 21-36). Washington, DC: American Psychiatric Press.

Young, G.H., & Gerson, S. (1991). New psychoanalytic perspectives on masochism and spouse abuse. *Psychotherapy, 28*(1), 30-38.

Young, L. (1992). Sexual abuse and the problem of embodiment. *Child Abuse and Neglect, 16*(1), 89-100.